EMERGENCY MEDICAL SERVICES
PREHOSPITAL DO NOT RESUSCITATE (DNR) FORM

An Advance Request to Limit the Scope of Emergency Medical Care

CALIFORNIA MEDICAL ASSOCIATION

I, _____, request limited emergency care as herein described.
(print patient's name)

I understand DNR means that if my heart stops beating or if I stop breathing, no medical procedure to restart breathing or heart functioning will be instituted.

I understand this decision will **not** prevent me from obtaining other emergency medical care by prehospital emergency medical care personnel and/or medical care directed by a physician prior to my death.

I understand I may revoke this directive at any time by destroying this form and removing any "DNR" medallions.

I give permission for this information to be given to the prehospital emergency care personnel, doctors, nurses or other health personnel as necessary to implement this directive.

I hereby agree to the "Do Not Resuscitate" (DNR) order.

_____ _____
Patient/Surrogate Signature Date

_____
Surrogate's Relationship to Patient

I affirm that this patient/surrogate is making an informed decision and that this directive is the expressed wish of the patient/surrogate. A copy of this form is in the patient's permanent medical record.

In the event of cardiac or respiratory arrest, no chest compressions, assisted ventilations, intubation, defibrillation, or cardiotonic medications are to be initiated.

_____ _____
Physician Signature Date

_____ _____
Print Name Telephone

_____
Address

THIS FORM WILL NOT BE ACCEPTED IF IT HAS BEEN AMENDED OR ALTERED IN ANY WAY

PREHOSPITAL DNR REQUEST FORM

White Copy: **To be kept by patient**
Goldenrod Copy: **To be kept in patient's permanent medical record**
Pink Copy: **If authorized DNR medallion desired, submit this form with Medic Alert enrollment form to: Medic Alert Foundation, Turlock, CA 95381**

INLAND COUNTIES EMERGENCY MEDICAL AGENCY
Serving San Bernardino, Inyo, and Mono Counties
515 N ARROWHEAD AVENUE
SAN BERNARDINO, CA 92415-0060
909-388-5823 FAX: 909-388-5825

DO NOT RESUSCITATE REPORT FORM

TODAY'S DATE: ____/____/____ DATE OF INCIDENT ____/____/____

EMT-P NAME _____ LOCAL ACCRED #: _____

EMPLOYER: _____ CONTACT TIME W/PATIENT:_____

PATIENT NAME: _____ PATIENT AGE: _____

ADDRESS: _____

LOCATION AT TIME OF ARREST: _____

TYPE OF DNR REQUEST

_____ DNR MEDALLION/BRACELET/NECKLACE ID#: _____

_____ PREHOSPITAL DNR FORM

_____ WRITTEN DNR ORDER or ADVANCED DIRECTIVE ON THE PATIENT'S CHART
(For Licensed Healthcare Facilities ONLY)

PATIENTS CONDITION UPON ARRIVAL: _____

WITNESSES PRESENT: _____

DISPOSITION OF PATIENT: _____

This DNR report form must be filed with the Base Hospital within 24 hours of the incident. The Base Hospital PLN shall review this report and forward a copy to the ICEMA QI Coordinator within 72 hours of the incident with any irregularities in policy noted, pursuant to Standard Practice Protocol, Reference #14008.

A COPY OF THE PATIENT CARE RECORD MUST BE ATTACHED

BASE HOSPITAL PLN COMMENTS: _____

_____

_____

_____

_____